Margiotti & Kroll PEDIATRICS, P.C.

Patient Policies & Consents

Today's Date:	Preferred Office: ☐ Trevose ☐ Newtown ☐ Valley Square ☐ Northeast ☐Oxford Valley

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Patient ID #:

AUTHORIZATION FOR TREATMENT & COMMUNICATION

- I hereby authorize all parents, guardians, family members, and caretakers to accompany the above-named patient to office visits at Margiotti & Kroll Pediatrics, P.C., and consent to the examination and/or treatment of the above-named patient during the office visits.
- Parents and/or guardians must be accurately recorded in the patient's electronic health record in order to obtain access to this patient's records via the Online Patient Portal.
- I hereby authorize Margiotti & Kroll Pediatrics, P.C. personnel to communicate via mail, phone call, answering machine message, text message, and/or e-mail according to the information I have provided above.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

NOTICE OF PRIVACY PRACTICES / HIPAA STATEMENT

I understand that, under the Health Insurance Portability and Accountability Act off 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy. I understand that Margiotti & Kroll Pediatrics, PC has the right to change its Notice of Privacy Practices. I understand that I may request in writing that Margiotti & Kroll Pediatrics can restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Margiotti & Kroll Pediatrics is not required to agree to my requested restrictions. I understand that this assignment will remain in effect until revoked by me in writing or when the patient reaches the age of eighteen.

I certify that I have been offered and/or have received a copy of Margiotti & Kroll Pediatrics, P.C.'s Notice of Privacy Practices.

Patient/Parent/Guardian Signature:	Date:

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

I understand that prescribing history for multiple other unaffiliated medical providers, insurance companies, and pharmacy benefits managers may be obtained and used by my Margiotti & Kroll Pediatrics provider and staff for treatment purposes, and it may include prescriptions issued back in time for several years. I am authorizing Margiotti & Kroll Pediatrics to obtain and use the external prescription history via the Med Hx service for the patient listed above.

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BILLING POLICY & FINANCIAL RESPONSIBILITY

- Insurance Information Required: At every visit you will be required to present the patient's current insurance information and update any guarantor/subscriber information.
- Claim Submission: We will submit claims for reimbursement for the majority of our services to all insurance carriers with which we participate. It is your financial responsibility to pay any remaining balance resulting from co-insurances, deductibles, non-covered services, etc.
- Enrollment Not in Effect/No Health Insurance: Patients/Guardians will be financially responsible for all professional charges incurred if service was provided when enrollment in a health plan was not in effect, our Practice was not properly selected as your primary care provider (when necessary), or if a patient has no health insurance.
- Know Your Insurance Plan: Each medical insurance plan has its own rules and regulations. We strongly encourage you to become familiar with your insurance plan. This includes, but is not limited to: knowledge of capitation requirements, referrals, co-payments, deductibles, covered and non-covered services, and other administrative requirements issued by your carrier.
- Co-Pay Due/Deductible Not Met/Co-Insurance Due: Patients/Guardians will be financially responsible for all co-pays due for services provided, if a deductible has not yet been met, or if there is a co-insurance due.
- High Deductible Health Plans (HDHP) & Co-Insurance Plans: We require patients with these plans to securely store their Health Savings account (HSA), Flexible Spending account (FSA), or Credit Card information on file so that we may process the charges associated with our services that are applied by your insurance company.
- Non-Covered Services: Patients/Guardians will be financially responsible for any professional changes incurred for a non-covered service for which their health plan will not make a payment; this can include hearing and vision screening.
- Forms & Letters of Medical Necessity: The completion of medical forms, health certifications, letters of medical necessity, or any other required medical documentation will be charged in accordance with our current fee schedule.
- Payment Due at Time of Service: We reserve the right to apply a billing fee for all co-payments that are not collected at the time of service. Please be sure to remit payment promptly upon receiving any bill.
- Collections Notice: Bills unpaid for more than 90 days will be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.
- Evening & Weekend Notice: We are dedicated to providing our services at times convenient to our patients. Please be aware that your insurance carrier may apply a higher co-pay or patient responsibility for a visit during our evening or weekend office hours.
- Walk-In & Emergency Fit-In Notice: We pride ourselves in providing unparalleled access to care for our patients when they are sick. This includes same and next day sick appointment availability along with walk-in hours in one or more of our office locations 365 days per year for acute illnesses. Please be aware that your insurance carrier may apply a higher co-pay or patient responsibility for these services.
- AAP Well Visit Recommendations: Our office adheres to the recommendations set forth by the American Academy of Pediatrics (AAP) for routine well child care including the schedule of well visits, immunizations, and preventative screenings. Please be aware that your insurance carrier may assign you a charge for these services.
- I acknowledge that I have read and understand the Notice of Billing Policy & Financial Responsibility listed above.

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ASSIGNMENT OF BENEFITS

- I authorize the release of pertinent information necessary to process my medical claim. I hereby assign all insurance benefits to which I am entitled, including private insurance and any other health plans to Margiotti & Kroll Pediatrics, PC for services rendered. The assignment will remain in effect until revoked by me in writing.
- I hereby authorize Margiotti & Kroll Pediatrics, P.C. and/or its subsidiaries to submit for reimbursement on my/our behalf for all services rendered and assign directly to Margiotti & Kroll Pediatrics, P.C. all insurance benefits otherwise payable to me.
- I understand that if my insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf.
- I hereby authorize Margiotti & Kroll Pediatrics, P.C. and associated parties to release medical and/or other information acquired in the course of my examination and/or treatment (with the exception of mental health records) to necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I certify that myself/my dependent(s) have health insurance coverage as provided.
- I understand that all co-pays, co-insurances, and deductibles are due at the time of service and that a billing fee will be added to any co-pays not paid at the time of service.
- I further understand that if Margiotti & Kroll Pediatrics, P.C. is unable to verify active insurance coverage for this patient and/or the claim for reimbursement is not paid by my insurance that the patient (or patient's guardian, if a minor) is ultimately responsible for payment for services rendered.
- I agree that any balance due for services rendered will be paid immediately upon receipt of a bill. In the event that I do not pay my bill, I understand that I will be held responsible for all reasonable collection and legal fees.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

SCHEDULED APPOINTMENT & ARRIVAL POLICY

Scheduled Appointments:

- Our practice makes every effort to run on time with appointments, as we believe everyone's time is equally valuable.
- As a courtesy, we provide automated reminders of your upcoming appointments via phone/text or message/email.

Late Arrival:

- We kindly ask that patients arrive five minutes before their scheduled appointment time. If you are late, we will try to accommodate you during the same session if the provider's schedule allows. However, this may require waiting until all scheduled patients have been seen or seeing an alternative provider if your original provider's schedule is full. If we are unable to fit you into the schedule, we may ask you to reschedule for a more convenient time.

Early Arrival:

- We appreciate your effort to arrive early for your appointment. Please note that patients are typically seen in the order of their scheduled appointment times, not their arrival time. If you arrive early, we will do our best to accommodate you as soon as possible. However, patients scheduled before you who arrive on time will be seen first. Additionally, when multiple providers are working, patients are seen based on their specific provider's schedule, which may make it seem like later arrivals are being taken back first.

Missed Appointments:

- Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. **We reserve the right to charge a fee of $35 for canceled or missed appointments**. We request 24 hours notice for cancellation of appointments.
- If you miss a second scheduled appointment without notifying the office as required, you will still have the opportunity to reschedule. However, if the missed appointment involved multiple children, we will not schedule consecutive back-to-back appointments in the future, as this could again prevent other patients from accessing those time slots.

Discharge from Practice:

- **Our office policy is to discharge patients from the practice that have three or more no-call/no-show visits per family**. This means an appointment was scheduled and the patient never showed and did not provide the office with prior notification that the appointment would be missed. Please note our discharged policy encompasses the entire family being discharged as the result of three or more no-call/no-show appointments.

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Patient/Parent/Guardian Signature:	Date:

PATIENT CENTERED MEDICAL HOME (PCMH) POLICY ACKNOWLEDGEMENT

As a Patient-Centered Medical Home (PCMH), Margiotti & Kroll Pediatrics serves as the central hub for managing all aspects of your child's medical care. This model emphasizes a strong partnership between you and our team to ensure comprehensive, coordinated, and patient-focused healthcare. By acknowledging this policy, you agree to:

- Utilize Our Practice as the Hub for Medical Care: Seek care through our practice for all non-emergency medical needs, ensuring continuity and quality of care.
- Coordinate Care Through Us: Understand that we are responsible for referring you to outside care, including specialists, urgent care centers, and emergency rooms, only when necessary and when services are beyond the scope of care we can provide within the medical home.
- Communicate Openly: Inform us of any care you receive outside of our practice to maintain accurate records and ensure coordinated treatment.

We are committed to providing you with the highest quality of care in a collaborative and supportive environment. Your active participation in this process is vital to the success of our partnership.

By signing below, you acknowledge your understanding of this policy and your responsibilities as a patient within our medical home.

Patient/Parent/Guardian Signature:	Date:

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PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Patient ID #:

VACCINATION POLICY

- We firmly believe in both the effectiveness and safety of the recommended vaccines for children and adolescents.
- We fully support the current vaccine schedule that is recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP). These schedules are continually studied and revised by experts in fields of medicine and immunology and public health.
- We fully believe based on all the current science and research that vaccines do not cause autism or other developmental disabilities. Furthermore, we believe that the thimerosal, a mercury-based preservative used in multi-dose vials (currently only the influenza vaccine), does not cause or trigger autism or worsen autism.
- We firmly believe that vaccinating children may be the single most important intervention we perform in health care.

That being said, we recognize that there has always been controversy surrounding routine vaccination and currently there is an erosion of trust. We are victims of our greatest successes in that we rarely see any of these vaccine-preventable infections. We take for granted that we have very high vaccinations rates. As a result of under-immunizing in pockets both in Europe and the US, we are now seeing outbreaks of both pertussis and measles. Both infections can result in hospitalization and even death. Both infections are completely preventable by vaccinations.

We understand it can be difficult to watch your children receive multiple injections at one time. As pediatric healthcare providers, we are hoping for more combination vaccines as much as you are. However, there is plenty of research to reassure us that giving multiple vaccines at once, though stressful, is not overwhelming to the immune system of any aged child. Please be advised that delaying or splitting up vaccines will just increase the interval during which your child is vulnerable to those infections. We believe that the CDC/AAP-recommended schedule is the safest and most effective for your child. Therefore, we do not endorse or follow any alternative immunization schedules.

When parents choose not to vaccinate, they not only place their child at risk from contracting a preventable disease, but they also place others in the community at risk. Unvaccinated children can serve as carriers, introducing a germ to children too young to be vaccinated, elderly family and friends, or people undergoing treatments for cancer or other serious medical conditions. We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to provide you the necessary information that will reaffirm that vaccination, according to schedule, is the right thing to do.

We also want you to recognize that when we receive urgent phone calls after hours, we assume that all children have received their routine vaccinations. For example, we would give very different advice on a routine call for a fever or a cough in a child who had not received vaccinations.

At each well visit, we will discuss the age-appropriate vaccines with you. We will be happy to address questions and concerns you may have about vaccines. We hope that you will agree that the best medical treatment for your child, the treatment that we have chosen for our own children, is to have your child fully vaccinated. Should you refuse to vaccinate your child, we will respectfully ask you to find another health care provider who will allow this vaccine refusal choice. As a point of fact, we do not keep a list of such providers, nor would we recommend any such physician.

By signing this document, I acknowledge that I have read this document and will follow the recommended vaccine schedule from the American Academy of Pediatrics (AAP).

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

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WELL VISIT VS. SICK VISIT POLICY

Thank you for trusting Margiotti & Kroll Pediatrics with your child's care. We know there's often confusion about the different types of visits we offer and how they are billed. Even if your insurance plan covers your visit to our Practice, you may be responsible for cost-sharing expenses, such as co-pays, co-insurance and deductibles. We hope the information below is helpful.

What is included in a well visit?

A preventive visit — also called a well visit — is a scheduled check-up focused on keeping your child's whole body healthy and safe. These checkups are recommended for infants, children and teens. Kids need one preventive visit every year from age 3 through age 21; babies and young toddlers need them more frequently. Our Practice follows the schedule recommended by the American Academy of Pediatrics for Preventative Pediatric Health Care. These appointments can include preventive care like:

- A general physical exam – This includes measuring height, weight and blood pressure, and other age-specific growth and development checks.
- Age-specific immunizations (vaccinations) such as chicken-pox, measles, whooping cough, hepatitis, etc.
- Age-specific screenings, such as hearing and vision screenings.

These visits are typically covered by your health insurance, often at no cost to you. Some of the specific tools used during screenings may be billed separately.

What is a sick (office) visit?

This type of visit is made when your child is having a specific health problem, illness or injury, or for management of chronic, ongoing health problems and/or medications. Reasons for this type of visit can include:

- Illness such as the flu, strep throat or an ear infection
- Injury
- Anxiety/depression
- ADHD management
- Other chronic condition

There is usually a cost for this type of visit. Your insurance provider may pass some or all of the costs to you. You may be responsible for a copay, co-insurance or deductible.

Can I be charged for both types of visits?

Sometimes at a well visit, an issue comes up that's not part of the regular check-up but that needs to be addressed during that visit. Your provider could address a problem to manage a condition or illness and may prescribe medication, order additional tests like lab work or X-rays, or refer you to a specialist.

In these cases, insurance requires us to bill the visit as both a well visit and a sick (office) visit, so you will likely have to pay an additional co-pay or co-insurance, or the cost will be applied to your deductible.

By signing this document, I acknowledge that I have read this document and agree that any balance assigned to me by my insurance for services rendered will be paid immediately upon receipt of a bill.

Patient/Parent/Guardian Name:	Relationship to Patient:
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DIVORCE/ SEPARATION OF PARENTS/GUARDIANS POLICY

(All parents/guardians must acknowledge this policy even if it does not currently apply)

Margiotti & Kroll Pediatrics, PC providers, and staff are dedicated to our patients and providing exceptional care to your child (ren). Our focus is on your child's medical, emotional, and physical needs. Our Practice will not get involved in legal issues involving divorce, separation, or custody agreements. Our medical providers and staff will not be put in the middle of domestic issues or disagreements over the phone or in the office of any kind.

It is vital that you make decisions regarding appointments (sick and well), vaccinating, and any office procedures in advance of visiting our office.

Only in situations where there is a confirmed, documented court order that has been previously provided to our office will one of the parents be denied access to the minor patient's medical records or visits at our practice. We must have a copy of this court order on file in the patient's electronic medical record.

If there is not a court order on file with our Practice, either parent or legal guardian, or previously assigned medical proxy may bring the child to our office, obtain medical record information, be present during the visit and consent to any treatment during the visit. Our providers and staff will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for a visit, and obtain medical record information (subject to medical records fee).

It is both parents' duty and responsibility to communicate with each other about the patient's care, appointments, and any additional necessary information relevant to the patient. It is not the responsibility of our providers or staff to communicate visit information to each custodial parent separately. We will not call the non-attending parent following visits. Additionally, we will not call the other parent for permission regarding appointments scheduled, restrict either parent's involvement in the patient's care unless required by law, or tolerate appointment scheduling/canceling behavior patterns between parents.

All payments for service including, but not limited to, co-pays, deductibles, coinsurance, or any additional charges are due at the time of service, regardless of which parent is responsible for medical expenses. We are not a party to your divorce agreement. We will collect payment from the parent who brings the child to the visit.

If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. If we feel any of the above points are becoming an issue at the office and compromising patient care, we have the right to discharge the family from the practice.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in being discharged from Margiotti & Kroll Pediatrics, PC.

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TELEMEDICINE TERMS OF SERVICE AGREEMENT

Margiotti & Kroll Pediatrics, PC may employ the use of telemedicine appointments when appropriate. In this event you acknowledge and agree:

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used. I am aware that this type of consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that a telemedicine consult is not intended to replace a full medical face-to-face evaluation by a provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate or assist with the technology associated with the visit. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
    a. omit specific details of my medical history/physical examination that are personally sensitive to me;
    b. ask non-medical personnel to leave the telemedicine examination room: and or
    c. terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me and have made the choice to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider. I assume the risk of the limitations set forth herein, and I further understand that no warranty or guarantee has been made to me concerning any particular result related to my condition or diagnosis.
6. I understand that billing to my insurance company will be done as a telemedicine visit and as such, I may be financially responsible for full or partial payment of any non-covered or partially covered service. I realize that it is my responsibility to contact my individual insurance carrier to ensure that telemedicine services are covered.
7. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By proceeding with a telemedicine visit, I certify:

- **That I have read or had this agreement read and/or had it explained to me**
- **I have given consent of my own free will (or by a parent or guardian)**
- **That I fully understand its contents including the risks and benefits of the procedure(s).**
- **That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.**

By signing this form, you agree to this terms of service agreement.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date: